

APPLICATION FOR RADIOLOGY LICENSE OR PERMIT

State Form 27068 (R13/3-07) Approved by State Board of Accounts, 2007

INSTRUCTIONS:

- 1. Fill out all blocks. This application will be returned to you without processing if any information is missing. If an item does not apply put "NA" in that block. Do not use abbreviations in any area on the application.

 2. Type or clearly print all information.
- 3. Make a personal check or money order for \$60 payable to: Indiana State Department of Health. (No fee is required for student or provisional permits.)
- 4. Send the completed form and fee to: Indiana State Department of Health, ATTN: Cashier's Offices, P.O. Box 7236, Indianapolis, IN 46207-7236.
- 5. You will receive your certificate from the Division of Medical Radiology Services or a letter indicating why your application was rejected.
- 6. If you have any questions, call AC 317/233-7565 Division of Medical Radiology Services or e-mail radiology@isdh.in.gov.
- 7. The disclosure of your Social Security Number is required in accordance with IC 4-1-8-1.

| Last Name: | | | I RAI- |
|---|-------------------------------|---------------------|---|
| | First Name: | | MI: |
| Home Address (number, street, P. O. Box): | | | |
| City: | State: | 9 Digit Zip C | ode: |
| Social Security Number: Home Phone N | Number: (Including area d | code) Date of Birth | h: (mm/dd/yyyy) |
| Category of Permit or License: | | | |
| Select one category of Po | ermit or License (<i>che</i> | eck one box only | <i>'</i>) |
| PERMIT: | | | |
| Student Radiography Student Nuclea | ar Medicine | Provisional Ra | adiography |
| Student Radiation Therapy Student Denta | I Radiography | | |
| LICENSE: | | | |
| Limited Chest Limited Dental | [| Limited Podia | tric |
| Limited Chiropractic Limited Cardia | c Catheterization [| Radiation The | rapy |
| Radiologic Technologist Nuclear Medic | cine Technologist | | |
| | | | |
| High School Education Information | | | |
| | ve number and Hi | High school: | |
| school? If yes, indicate the date: date: | Lo | cation: | |
| Yes or No/_/ | | | |
| Approved Educational Program: | | | |
| Name of School: Location of School: | Date Enrolled | | Date Graduated or Projected to Graduate: (mm/dd/yyyy) |

| | ofessional Information: (License only) | | |
|----------------------------|---|---|---------|
| Ch | eck appropriate professional examination/certification you have comple | eted (<i>if any</i>): | |
| | ARRT Radiography Certification ARRT Limited Scope Examination | DANB Certified Dental Assistant | |
| | DANB Dental Radiation Health and NMTCB Nuclear Safety Examination Medicine | ARRT Radiation Therapy Certification | |
| Со | ompliance Information: | | |
| An | swer each of the following questions "Yes" or "No". If you answer to some second to the following questions are second to the following questions | er any of the questions "Yes", please | е |
| Ha | ve you ever been convicted of a felony? | → □ Yes □ No | 0 |
| Ha | ve you ever been denied or had a license/certification revoked? | Yes No |) |
| | ve you ever been formally notified of any complaint against you relative the practice of radiologic technology? | e Yes No |) |
| dis | you have a drug or an alcohol abuse problem or any mental or physicability that, through the practice of your duties, may be dangerous patients or public? | ral Yes ☐ No |) |
| | | | |
| Ар | plicant Agreement: | | |
| In o | consideration of the granting to me a permit/license, I do hereby agree the Indiana State Department of Health, and to permit the Department, reasonable times, opportunity to inspect my permit/license. | | |
| In of tall | consideration of the granting to me a permit/license, I do hereby agree the Indiana State Department of Health, and to permit the Department, | or its duly authorized representative, a on this application is accurate and true | at |
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